EDMUND G. BROWN JR.
Attorney General of California
JAMES M. LEDAKIS,
Supervising Deputy Attorney General
KAREN L. GORDON
Deputy Attorney General
State Bar No. 137969
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-3037
Facsimile: (619) 645-2061
*Attorneys for Complainant*

**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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|---|---|
| In the Matter of the Accusation Against:<br><br>**CHARLENE MARY ANDERSON**<br>**817 N. Tremont Street**<br>**Oceanside, CA 92054**<br><br>**Registered Nurse License No. 461728**<br><br>Respondent. | Case No. 2010-298<br><br>**FIRST AMENDED ACCUSATION** |

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

**PARTIES**

1. Complainant brings this First Amended Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 31, 1991, the Board of Registered Nursing issued Registered Nurse License Number 461728 to Charlene Mary Anderson (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2010, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

## STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

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## REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

9. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, . . . .

## COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board/Registrar/Director may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

11. **DRUGS**

**"Percocet"** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision ((b)(1)(N), and a dangerous drug per Business and Professions Code section 4022. **Percocet** is a brand name for the generic drug o**xycodone** with **acetaminophen** and is used to treat pain.

**"Vicodin"** is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(4) and a dangerous drug per Business and Professions Code section 4022. **Vicodin** is a brand name for the generic drug **hydrocodone**. It is also known as dihydrocodeinone with the non-narcotic substance acetaminophen and is used to treat pain.

**"Tylenol 3"** is a Schedule III controlled substance pursuant to Health and Safety Code section 11055 and a dangerous drug per Business and Professions Code section 4022. **Tylenol 3** is a generic name for codeine with acetaminophen and is a narcotic pain reliever (analgesic).

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## FIRST CAUSE FOR DISCIPLINE

**(Incorrect and/or Inconsistent Entries in Hospital and/or Patient Records)**

12. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), based upon the following:

**Scripps Memorial Hospital**

13. Respondent was employed as a registered nurse at Scripps Memorial Hospital from August of 2002 until her termination in November of 2006. Between or about May 4, 2006, and August 29, 2006, while on duty as a registered nurse at Scripps Memorial Hospital, Respondent made grossly incorrect or grossly inconsistent entries in hospital and/or patient records, as follows:

Patient 1 BP

a. On May 4, 2006, at 1028 hours, Respondent removed two Percocet tablets from the Pyxis[1] machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 2 SM

b. On May 16, 2006, at 1828 hours, Respondent removed one Percocet tablet from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. One Percocet tablet was unaccounted for.

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[1] Pyxis is a trade name for the automated single-unit does medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a "user ID" code to operate the control panel. The user is required to enter a second code "PIN" number, similar to an ATM machine, to gain access to the medications. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as wastage. This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine

Patient 3 JLH

c. On July 10, 2006, at 0027 hours, Respondent removed one Percocet tablet from the Pyxis machine for this patient. There was no Physician Order for Percocet for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. One Percocet tablet was unaccounted for.

Patient 4 KC

d. On July 18, 2006, at 0048 hours, Respondent removed one Percocet tablet from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. One Percocet tablet was unaccounted for.

Patient 5 AC

e. On August 2, 2006, at 2002 hours, Respondent removed one Percocet tablet from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 5 AC

f. On August 2, 2006, at 2315 hours, Respondent removed Two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 5 AC

g. On August 3, 2006, at 0139 hours, Respondent removed two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 5 AC

h. On August 3, 2006, at 0524 hours, Respondent removed two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

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Patient 6 AP

i. On August 28, 20906, at 1223 hours, Respondent removed two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 6 AP

j. On August 28, 2006, at 1531 hours, Respondent removed two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 6 AP

k. On August 29, 2006, at 1023 hours, Respondent removed two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 6 AP

l. On August 29, 2006, at 1317 hours, Respondent removed two Percocet tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 6 AP

m. On July 13, 2006, at 1502 hours, Respondent removed two Hydrocodone tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Percocet tablets were unaccounted for.

Patient 6 AP

n. On July 13, 2006, at 2112 hours, Respondent removed two Hydrocodone tablets from the Pyxis machine for this patient. No Medication Record, Nursing Notes, nor Wastage were charted by Respondent. Two Hydrocodone tablets were unaccounted for.

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Patient 7 AS

o. On July 14, 2006, at 0046 hours, Respondent removed two Hydrocodone tablets from the Pyxis machine for this patient. Respondent charted in this patient's Medication Chart that one (1) tablet was administered. There were no Nursing Notes and no Wastage charted by Respondent. One tablet of Hydrocodone was unaccounted for.

Patient 8 LCW

p. On August 8, 2006, at 0818 hours, Respondent removed two Hydrocodone tablets from the Pyxis machine for this patient. There were no Medication Record, Nursing Notes nor Wastage charted by Respondent. Two tablets of Hydrocodone were unaccounted for.

Patient 9 SB

q. On July 6, 2006, at 0437 hours, Respondent removed one Tylenol with Codeine tablet from the Pyxis machine for this patient. There was no Physician Order for Tylenol with Codeine for this patient. There were no Medication Record, Nursing Notes nor Wastage charted by Respondent. One tablet of Tylenol with Codeine was unaccounted for.

Patient 10 MM

r. On August 20, 2006, at 1626 hours, Respondent removed two Tylenol with Codeine tablets from the Pyxis machine for this patient. There were no Medication Record, Nursing Notes nor Wastage charted by Respondent. Two tablets of Tylenol with Codeine were unaccounted for.

## SECOND CAUSE FOR DISCIPLINE

**(Unprofessional Conduct - Unlawfully Obtaining/Possessing Controlled Substances and/or Dangerous Drugs)**

14. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that while employed as a registered nurse, Respondent obtained or possessed dangerous drugs in violation of the law as set forth in paragraph 13, above, which is incorporated herein by this reference.

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## THIRD CAUSE FOR DISCIPLINE

**(Incompetence or Gross Negligence)**

15. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), on the grounds of incompetence or gross negligence, in that between or about May 4, 2006 and August 29, 2006, while employed as a registered nurse, Respondent failed to chart the administration of thirty-three (33) narcotic tablets in patients' MAR's, as is more fully described in paragraph 13, above.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 461728, issued to Charlene Mary Anderson Charlene Mary Anderson;

2. Ordering Charlene Mary Anderson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/14/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

SD2009804891